Optometric and Eyeglass Services

Provided by:

Ophthalmologists, Optometrists, Opticians and Eyeglass Providers

Medicaid , CHIP and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

October 2005

This publication supersedes all previous Optometric and Eyeglass Services provider handbooks. Published by the Montana Department of Public Health & Human Services, March 2003.

Updated July 2003, April 2004, January 2005, April 2005, August 2005, October 2005.

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

My Medicaid Provider ID Number:
My CHIP Provider ID Number:

MONTANA
Department of Public Health & Human Services

Table of Contents

Montana Department of Public Health and Human Services

Montana Department of Public Health and Human Services

descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Retroactive Eligibility

Medicaid does not cover eyeglasses for clients who become retroactively eligible for Medicaid when the eyeglasses were purchased before retroactive eligibility was determined. However, Medicaid does cover eye exams for retroactively eligible clients. For example, suppose that a client had an eye exam and purchased eyeglasses on July 15. On September 1, the Department determined the client was eligible for Medicaid retroactive to July 1. Medicaid would pay for the eye exam but not for the eyeglasses.

Coverage of Specific Services

The following are coverage rules for specific services provided by optometrists, opticians, and ophthalmologists. Due to limits on exams and eyeglasses, before providing these services, the provider should contact Provider Relations (see *Key Contacts*) to verify the client is currently eligible for an exam, and contact the eyeglass contractor (see *Key Contacts*) to verify the client is eligible for eyeglasses. Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor (see *Key Contacts*). All services are subject to post payment review and payment recovery if they are not medically necessary (see the *Surveillance/Utilization Review* chapter in the *General Information For Providers* manual).

Medicaid will only pay for eyeglasses and frames purchased through the Department's eyeglass contractor

Contact lenses

Contact lenses are covered only when medically necessary and not for cosmetic reasons. Dispensing providers must obtain prior authorization for all contact lenses and dispensing fees (see the *Prior Authorization* chapter in this manual). The same limits that apply to eyeglasses and repairs also apply to contacts. Contact lenses are not provided by the eyeglass contractor and therefore may be provided by other providers. Medicaid covers them when the client has one the following conditions:

- Keratoconus
- Sight that cannot be corrected to 20/40 with eyeglasses
- Aphakia
- Anisometropia of 2 diopters or more

If a provider does not check client eligibility prior to an exam, and the claim is denied because the client's exam limit was exceeded, the provider cannot bill Medicaid or the client.

Adults (age 21 and older) are limited to one eye exam and one pair of eyeglasses every 730 days. Children (ages 20 and under) are limited to one eye exam and one pair of eyeglasses every 365 days.

Eye exams

Before providing an eye exam, verify that the client is eligible for an exam by contacting Provider Relations (see *Key Contacts*). Medicaid clients ages 21 and over are limited to one eye examination for determining refractive state every 730 days. Medicaid clients ages 20 and under are limited to one eye examination for determining refractive state every 365 days. The Department allows exceptions to these limits when one of the following conditions exists:

- Following cataract surgery, when more than one exam during the respective period is necessary
- A screening shows a loss of one line acuity with present eyeglasses
- Adult diabetic clients may have exams every 365 days

Eyeglass services

Before providing eyeglasses to a client, verify that the client is eligible by contacting the eyeglass contractor (see *Key Contacts*). Adults ages 21 and older are eligible for eyeglasses every 730 days. If the client has a diagnosed medical condition that prohibits the use of bifocals, Medicaid may cover two pairs of single vision eyeglasses every 730 days. Although prior authorization is not required, the provider must document the client's inability to use bifocals. Children ages 20 and under are eligible for eyeglasses every 365 days. If one of the following circumstances exists within the respective time limits, lenses only will be replaced:

- .50 diopter change in correction in sphere
- .75 diopter change in cylinder
- .5 prism diopter change in vertical prism
- .50 diopter change in the near reading power
- A minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters
- A minimum of a 3 degree change in axis of any cylinder greater than 3.00 diopters
- Any 1 prism diopter or more change in lateral prism

If any one of these changes is in one eye, Medicaid will cover that lens only. Medicaid will not cover a new frame at the time of a prescription change within the respective time limits.

Eyeglasses are covered for an initial/new prescription when the client has at least one of the following circumstances in one or both eyes:

- cataract surgery
- .50 diopter change in correction in sphere
- .75 diopter change in cylinder
- .5 prism diopter change in vertical prism

- .50 diopter change in the near reading power
- Any 1 prism diopter or more change in lateral prism

Frame services

The eyeglass contractor will provide a list of Medicaid-covered frames to dispensing providers.

Medicaid clients have the option of using their "existing frames" and Medicaid will cover lenses. The existing frame is a frame that the client owns or purchases. When a client chooses to use an existing frame, the following apply:

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglass contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglass contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the client), Medicaid will pay for a contract frame but not new lenses. The client can choose to pay privately for new lenses or find a contract frame that the lenses will fit. New lenses are not covered in this case.

Lens add-ons

Medicaid covers some "add-on" or special features for eyeglass lenses, and some are available on a private pay basis (see following table).

Lens Add-Ons

Lens Feature	Medicaid Covers for Children (Ages 20 & Under)	Medicaid Covers for Adults (Ages 21 and Older)	Medicaid Contract Rate Per Lens
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary	No	$18.50
Photochromic - Glass (i.e. photogray, photobrown)	Yes - if medically necessary	No	$4.50
Progressive	No, but Medicaid will pay $21.00 and client must pay balance	No, but Medicaid will pay $21.00 and client must pay balance	VIP $30.50 XL $30.50 Percepta $34.00 Comfort $35.50
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes - if client is monocular	Yes - if client is monocular	$4.00
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	Yes	No charge

Montana Department of Public Health and Human Services

Lens Add-Ons (continued)

Lens Feature	Medicaid Covers for Children (Ages 20 & Under)	Medicaid Covers for Adults (Ages 21 and Older)	Medicaid Contract Rate Per Lens
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary	No	$1.25
UV and scratch-resistant coatings	Yes - if medically necessary	No	$1.50
Slab-off and fresnell prism	Yes - if medically necessary	Yes - if medically necessary	No charge

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted above or within this manual will be billed to the dispensing provider at the eyeglass contractor's normal and customary charges. The Department requests that providers bill clients the Walman Medicaid rate for scratch guard and polycarbonate lenses. For other add-ons noted above that are not covered by Medicaid, payment is a private arrangement between the client and the provider. This means that the provider may charge either the usual private pay rate or the Walman Medicaid rate to the client.

Lens styles and materials

All eyeglass lenses fabricated by the eyeglass contractor for Medicaid clients must be in the edged form, edged to shape and size for a specific frame and returned to the dispensing provider as "lenses only," or edged and mounted into a specific frame and returned to the dispensing provider as "complete Rx order." Orders for "uncut" lenses are not accepted.

Medicaid covers the following lens styles:

- Single vision
- Flattop segments 25, 28, 35
- Round 22
- Flattop trifocals 7 x 25, 7 x 28
- Executive style bifocals.

Medicaid covers the following lens materials (no high index):

- Glass
- CR-39
- Polycarbonate for monocular clients only. Medicaid clients who are not monocular can choose polycarbonate lenses and pay the difference as an add-on (see previous table of *Lens Add-Ons*).

Montana Department of Public Health and Human Services

Replacement lenses and frames

All frames provided by the Medicaid contractor carry a 24-month manufacturer warranty on replacement fronts and temples. Medicaid clients must bring their broken frames into the dispensing provider for the contractor to repair. No new frame style or color can replace the broken frame.

If an adult (ages 21 and older) loses his or her eyeglasses within the 24 months, Medicaid will not cover another pair. If an adult's lenses are broken or unusable, the client is eligible for replacement lenses (not frames) 12 months after the initial dispensing of contract eyeglasses.

Eyeglass Breakage and Loss Form

A. TO BE COMPLETED BY THE PATIENT

Please check one of the following reasons why you are requesting replacement of your eyeglasses.

☐ Eyeglasses have been lost or stolen (children only).
☒ Frame is broken.
☐ One lens is unusable due to scratches or breakage.
☒ Both lenses are unusable due to scratches or breakage.
☐ Other. Please explain_____

12/10/02 Julie Smith
Date Patient Signature (parent for a minor)

##########

B. TO BE COMPLETED BY PROVIDER

☒ Patient brought in broken: (frame) lens / (lenses.)
(Circle Applicable)

12/10/02 Alex Optometrist
Date Provider Signature

If a child (ages 20 and under) loses or breaks the first pair of eyeglasses, and the damage is not covered by the warranty, Medicaid will replace one pair of eyeglasses within the 365 day period. Additional replacement requests must be reviewed by the Department Program Officer (see *Key Contacts*). Parents/guardians may purchase additional replacement eyeglasses at the Medicaid contract rate.

For lens and/or frame replacements, complete an *Eyeglass Breakage and Loss* form (see sample). Please circle *lens* if one lens is broken, and *lenses* if both lenses are broken. This form may be copied from *Appendix A Forms* or downloaded from the website.

Eyeglass Ordering Procedures

Providers must complete the Montana Medicaid Rx Form to order eyeglasses from the Department's contractor (see *Appendix A Forms*).

Tips for completing the Montana Medicaid Rx Form

- The date of service for dispensing eyeglasses (measuring, verifying, and fitting) is the date the eyeglasses are ordered from the contractor.
- The date of service for eyeglass materials is the date the order is received by the eyeglass contractor.
- Encounters with the client on and after the date the glasses are dispensed are considered follow-up and are covered within the measuring, verifying, and fitting fee.

When the date of service is near the end of the month, please fax orders to the eyeglasses contractor before 3:00 p.m. to ensure the client's eligibility, which can change monthly.

- Orders received by the eyeglass contractor after 3:00 p.m. will appear on the next business day and billed with this date of service.
- When the date of service is near the end of the month, please fax orders to the contractor. This will help ensure the client is eligible for eyeglasses since eligibility can change monthly. If you experience any difficulty faxing the contractor, please contact the contractor manager immediately (see *Key Contacts*).
- When completing the *Frame Information* section, remember the following:
  - Select *Supply* when ordering contract frame and lenses
  - Select *Lenses Only* when ordering lenses only
  - Check the *EPSDT* box when the Medicaid client is age 20 and under
  - *2nd PR S.V.* is used when ordering two pairs of single vision eyeglasses (one for distance and one for reading) when a Medicaid client cannot wear multi-focal eyeglasses. An ophthalmologist or optometrist must keep documentation of the client's inability to wear multi-focal eyeglasses.
  - *Rx Change* is used when a lens is ordered due to a prescription change which meets Medicaid guidelines (see *Eyeglass services* earlier in this chapter).

Submitting the Medicaid Rx form

- Attach a copy of the Faxback or MEPS printout verifying eligibility for the client (see the *Verifying Client Eligibility* section in the *General Information For Providers* manual) to the order form.
- If the service is "essential for employment," include a copy of the form with the order.
- Mail or fax the order form to the eyeglass contractor (see *Key Contacts*). Phone orders are not accepted. To ensure orders will be processed accurately and on time, all sections of the order form must be completed.
- Errors in the fabrication of eyeglasses made by the eyeglass contractor will be corrected by the contractor at no additional charge.
- If the dispensing provider makes a mistake on a prescription, the eyeglass contractor will correct the error (create a new lens with the correct prescription) and bill the dispensing provider at Medicaid contract rates.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Children's Health Insurance Plan (CHIP)

Eyeglass services are covered by CHIP, but optometric services are covered by the BlueCHIP Plan of Blue Cross and Blue Shield of Montana (see *Key Contacts*). Most of the eyeglass services information in this chapter applies to CHIP clients. The exceptions are as follows:

- Where the above text says "Medicaid covers," either CHIP or BlueCHIP covers for CHIP clients.
- CHIP clients do not receive retroactive eligibility.
- CHIP clients are 18 years of age and under.
- CHIP clients are eligible for eyeglasses every 365 days.
- CHIP clients are not eligible for replacement lenses or frames that are not covered under warranty.

Additional information regarding CHIP is available on the *Provider Information* website (see *Key Contacts*).

Mental Health Services Plan (MHSP)

Eye exams and eyeglasses are not covered under the Mental Health Services Plan (MHSP). See the *Mental Health Services Plan* manual available on the *Provider Information* website.

Lens add-ons

The eyeglass contractor bills the dispensing provider their usual and customary charge for any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not covered by Medicaid (see *Covered Services*, *Lens add-ons*). It is the dispensing provider's responsibility to bill the Medicaid client for these items. Do not bill Medicaid.

For example, FT7x35 Trifocal is billed to the dispensing provider at the contractor's usual and customary price, not at a price which would reflect the difference between the contract price for 7x28, and the usual and customary 7x35 price.

For FT 28 CR-39 with polished edges, only the polished edge price is billed to the dispensing provider at the contractor's usual and customary charge.

Replacement lenses and frames

If a client has selected to use an existing frame, and the existing frame breaks after lenses were dispensed to the client, Medicaid will not cover new lenses. The Medicaid client may privately pay for new lenses or select a contract frame that the existing lenses will fit into. If a contract frame is selected, the dispensing provider may bill Medicaid for dispensing services, frame only.

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact the EDI Technical Help Desk (see *Key Contacts*).

- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	**888888888**	-	**11182003**
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

The *Provider Information* website contains billing instructions, manuals, notices, fee schedules, answers to commonly-asked questions and much more (see *Key Contacts*). The information available may be downloaded and shared with others

Montana Department of Public Health and Human Services

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City State Zip

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

WINASAP 2003
WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact the EDI Technical Help Desk (see *Key Contacts*).

Index

Montana Department of Public Health and Human Services

D

Montana Department of Public Health and Human Services

E

F

G

Montana Department of Public Health and Human Services

H

I

K

L

M

Montana Department of Public Health and Human Services

N

O

P

Montana Department of Public Health and Human Services

Q

R

S

Montana Department of Public Health and Human Services

T

U

V

W

Montana Department of Public Health and Human Services